FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

INFORMATION FOR FEDERAL CIVILIAN EMPLOYEES AND U.S. POSTAL SERVICE EMPLOYEES

United States
Office of
Personnel
Management

FPM Supplement 890-1
GSA Control No. 2809-219
NSN 7540-00-130-8501

SF-2809-A
Rev. June 1990

TO EMPLOYEES:

One of the benefits of working for the Government is the protection against the cost of medical care available to you through the Federal Employees Health Benefits (FEHB) Program. This pamphlet contains information about your rights and obligations under the Program and describes its major features. The information may be subject to change because of statutory or regulatory revisions that take effect after publication. Your employing office can give you the most up-to-date information.

To aid you in selectin the health care protection best suited to your needs, you should review the most current FEHB Enrollment Information Guide and Plan Comparison Chart applicable to you (see below) and the official brochure for the health benefits plan or plans in which you are interested. These may be obtained from your employing office.

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT

FEHB Enrollment Information Guide and Plan Comparison Chart Booklets for Employees

RI 70-1 Federal Employees (Non-Postal)

RI 70-2 Postal Employees

RI 70-5 Individuals Eligible for Temporary Continuation of FEHB Coverage

RI 70-6 Individuals Receiving Compensation from the Office of Workers' Compensation Programs (OWCP)

RI 70-7 Employees in Positions Outside the Continental U.S. (including Alaska, Hawaii, Guam and Puerto Rico)

RI 70-8 Temporary Employees Eligible for FEHB under 5 U.S.C. 8906a

RI 70-10 Visually Impaired Employees

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PARTICIPATION IS VOLUNTARY

The Federal Employees Health Benefits Program helps protect you and your family members from the expenses of illness and accident. It is a voluntary program. Whether you enroll or not is entirely up to you; but, if you are eligible, you are encouraged to enroll for this protection. If you do enroll, you may cancel your enrollment at any time. If you don't enroll at your first opportunity, you won't be able to enroll until Open Season or until anothe revent permitting enrollment occurs (see the table on page 13).

IMPORTANT

You will not be eligible for health benefits coverage after retirement unless you are enrolled before you retire and meet all the requirements for continuation of enrollment after retirement (see page 8).

WHO IS ELIGIBLE TO ENROLL

All permanent employees with regularly scheduled tours of duty and temporary employees whose appointments are for longer than on year are eligible to enroll in the FEHB Program. Also eligible to enroll are temporary employees with an appointment for one year or less who have completed one year of current, continuous employment, excluding any break in service of five days or less. Employees whose appointments are intermittent (without a prearranged regular tour of duty), or short-term (limited to one year or less) are not eligible to enroll.

WHAT THE PROGRAM OFFERS YOU

- An opportunity, within 31 days from the date of your appointment (or from the date you become eligible), to enroll in a health benefits plan with group-rated premiums and benefits.
- An annual opportunity, during Open Season, to enroll in a health benefits plan if you are not already enrolled or, if you are enrolled, to change to another plan or option.
- A choice of plans and options so that you can get the kind and amount of protection best suited to your personal and family health needs and finances.
- Guaranteed protection that can't be canceled by the plan.
- Coverage without medical examination or restrictions because of age, current health or pre-existin medical conditions. (Plans may limit benefits for dentistry or cosmetic surgery to conditions arising after the effective date of coverage.
- Coverage without waiting periods after the effective date of enrollment.
- Catastrophic protection against unusually large medical bills. (Fee-for-service plans limit the amount of covered expenses you would have to pay out-of-pocket for yourself and your family; prepaid plans provide or arrange for all necessary care.)
- A Government contribution toward the cost of your plan (unless you are a temporary employee required to pay both the Government and employee shares of the cost).
- The payroll deduction method of making premium payments.
- Extended protection for 31 days without cost to you after your enrollment or coverage of a family member ends (unless you voluntarily cancel).
- Under certain circumstances, an opportunity for temporary continuation of group coverage or conversion to nongroup coverage if your enrollment ends or a covered family member loses eligibility for coverage.
- If you meet certain requirements, continued protection for you and eligible family members after your retirement or while you are receiving compensation from the Office of Workers' Compensation Programs for a work-related injury.
- If certain conditions are met, continued protection for your eligible family members after your death.

COST OF ENROLLMENT

Unless you are a temporary employee who is required to pay the total cost, you and the Government share the cost of your enrollment. Under current law, the Government pays 60 percent of the average high option premium of six of the largest health benefits plans in the Program, but not more than 75 percent of the total premium for any plan. (For Postal employees, the Postal Service pays 75 percent of the average of the "Big 6," but not more than 93.75 percent of the total premium.) After the Government contribution is deducted from the total cost, you pay the remainder of the premium through salary withholdings. Premiums are adjusted annually; the amount you would currently pay under any plan in the Program is shown in the most recent **Enrollment Information Guide and Plan Comparison Chart** applicable to you (see page 2).

Note 1: The formula utilized to compute the Government contribution has been modified for 1990 (and 1991), because of the departure from the FEHB Program of the Aetna Indemnity Plan, whose high option premium had been used in computing the Government's share prior to 1990.

Note 2: If you are a part-time employee appointed under the Federal Employees Part-Time Career Employment Act of 1978, you should contact your employing office for information about the cost of enrollment. Only a portion of the Government contribution is paid toward your total premium. Therefore, **your** share of the premium will be **greater** than the amount that appears in the Enrollment Information Guide and Plan Comparison Chart.

TYPES OF PLANS AVAILABLE

The two basic types of health benefits plans available to you under the FEHB Program are fee-for-service plans and prepaid plans.

Fee-for-Service Plans

These plans reimburse you or the health care provider for covered services. If you enroll in one of these plans, you may choose your own physician, hospital and other health care providers.

Fee-for-service plans include the Service Benefit Plan administered by Blue Cross and Blue Shield and plans sponsored by unions and other employee organizations.

The Blue Cross and Blue Shield plan is open to all Federal employees. Some employee organization plans are open to all Federal employees who hold full or associate memberships in the organizations that sponsor the plans; the other employee organization plans are restricted to employees in certain occupational groups and/or agencies. Generally, the employee organizations require you to pay a membership fee or dues in addition to your health plan premium. (Such membership charges are paid directly to the employee organizations and are not part of the FEHB Program.)

Prepaid Plans

These are the Comprehensive Medical Plans/Health Maintenance Organizations (CMP/HMOs) that provide or arrange for health care by designated plan physicians, hospitals, and other providers in particular locations. CMP/HMOs are either Group Practice Plans. Individual Practice Plans or a combination of both (called Mixed Model Plans). Group Practice Plans provide care through a group of physicians who practice at medical centers operated by or under contract to the plans. Individual Practice Plans provide care through participating physicians who practice in their own offices.

Each CMP/HMO is open to all Federal employees who live within the plan's enrollment area. It is very important that you are sure you live in the plan's enrollment area before you enroll in one of these plans. The enrollment area is described in the plan's brochure.

TYPES OF ENROLLMENT

Each FEHB plan has two types of enrollment: (1) self only and (2) self and family.

Self Only Enrollment

This enrollment provides benefits only for you.

Self and Family Enrollment

This enrollment provides benefits for you and your eligible family members.

Family Members Eligible for Coverage

- Your spouse.
- Your unmarried dependent children under age 22, including legally adopted children.
- Your unmarried dependent recognized children under age 22 born out of wedlock:

  Who live with you in a regular parent-child relationship; or

  For whom a judicial determination of support has been obtained; or

  To whose support you make regular and substantial contributions.
- Your unmarried dependent stepchildren under age 22 if they live with you in a regular parent-child relationship.
- Your unmarried dependent foster child (or children) under age 22 if:

  The child (who may or may not be related to you) lives with you in a regular parent-child relationship; and

  You are raising the child as your own, exercising full parental responsibility and control; and

  You expect to continue to raise the child indefinitely into adulthood.
- A child is not a foster child for health benefits purposes if:

  The child is temporarily living with you as a matter of convenience; or

  A welfare or social service agency places the child in your home and retains control of the child; or

  A natural parent of the child also lives with you and is able to exercise or share parental responsibility and control.
- Your unmarried dependent children age 22 or over who are incapable of self-support because of physical or mental incapacity that existed before their 22nd birthday; the incapacity must be expected to last at least one year from the date of medical certification of incapacity. (Ask your employing office about the medical certification required for a child age 22 or over. If the child is not yet 22, you should submit the medical certificate to your employing office at least 30 days before the child's 22nd birthday.)

All eligible family members are covered under a self and family enrollment; you can't decide to cover some and exclude others. However, other relatives -- for example, your parents or grandchilren (unless a foster parent-child relationship exists) -- are not eligible for coverage as family members even though they live with you and are dependent upon you.

Events Causing Family Members to Lose Eligibility for Coverage

If family member is----	Event----
Your wife or husband ...	Divorce or annulment of marriage.
A child under age 22 ...	Marriage or attainment of age 22. (A child whose marriage ends before age 22 may again become eligible.)

Note: You will not be notified by either your employing office or your plan when your child loses eligibility because of age. As indicated on page 11, if your child wants to temporarily continue group coverage, you must notify your employing office of the child's loss of eligibility for coverage as a family member within 60 days after his or her 22nd birthday; if he or she wants to convert to nongroup coverage, you or the child must apply to the carrier of your plan for a conversion contract within 31 days after his or her 22nd birthday.

A disabled chid age 22 or over _____ Marriage or recovery of ability for self-support.

- Family members lose eligibility for coverage on the day that any of the above events occurs, subject to the 31-day extension of coverage for conversion to a nongroup health benefits contract (see page 10).

- You do not have to notify your employing office when a family member loses eligibility for coverage if at least one other eligible family member remains covered by your self and family enrollment. However, if your spouse loses eligibility because of your divorce, you should promptly notify your plan in writing. (See also Enrollment of Former Spouses below, Conversion Rights on page 10 and Temporary Continuation of Coverage on page 10.)

- If you become the only person covered by your self and family enrollment, you may immediately change to a less expensive self only enrollment. To do this, obtain a Health Benefits Registration Form (Standard Form (SF) 2809) from your employing office, complete the form and return it to your employing office.

Coverage of New Family Members

Self Only Enrollment

You must change to a self and family enrollment if you want to provide coverage for a new family member, *e.g.*, a newborn child or a new spouse. To do this, find the event that permits the change in the table on page 13 to determine when you can change. Then complete an SF 2809 and give it to your employing office within 60 days after a change in family status or anytime between 31 days before and 60 days after a change in mariital status.

Self and Family Enrollment

A new family member is automatically covered under your self and family enrollment, but your plan may ask you for information to verify the family member's eligibility when a claim for benefits is filed for that person.

IMPORTANT

Your employing office does not monitor changes in your marital or family status and will not automatically change your enrollment. If you need to change your enrollment from self only to self and family or vice versa, you must file an SF 2809 with your employing office. See the table on page 13 to find out when such changes may e made.

ENROLLMENT OF FORMER SPOUSES

Certain former spouses of employees (and of former employees and annuitants), whose marriage ended before the employee's (or former employee's or annuitant's) death, may enroll in the FEHB Program under the Spouse Equity law or similar statutes. Once enrolled, former spouses must pay the total premium for the plan they select, including the Government share. (See Cost of Enrollment on page 4). For further information about the enrollment of former spouses, contact your employing office.

Note: Former spouses who are not eligible to enroll under the Spouse Equity law (or similar statutes) may be eligible to continue FEHB coverage on a temporary basis (see page 10).

DUAL ENROLLMENT

Normally, you may not enroll or be enrolled as an employee if you are covered as a family member under someone else's enrollment in the FEHB Program. However, such dual enrollments may be permitted under certain circumstances in order to --

- Protect the interests of children who otherwise would lose coverage as family members, or

- Enable an employee who is under age 22 and covered under a parent's enrollment and become the parent of a child to enroll for self and family coverage.

No person (employee or family member) is entitled to receive benefits under more than one enrollment in the Program.

Your employing office can give you details about permissible dual enrollments.

OPPORTUNITIES TO ENROLL OR CHANGE ENROLLMENT

New or Newly Eligible Employees

You are required to complete a Health Benefits Registration Form (Standard Form (SF) 2809) obtained from your employing office. You must indicate on the form whether you want to enroll or do not want to enroll in an FEHB plan.

You must return the completed SF 2809 to your employing office:

Within 31 days after----	**If you are a----**
Your date of appointment	New employee.
The date you become eligible to enroll	Newly eligible employee.

All Eligible Employees

If you are not enrolled, you will be able to enroll only when an event permitting enrollment occurs. Such events, which are listed in the table on page 13, include (but are not limited to) --

- Open Season.
- Change in marital status.
- Loss of coverage as a family member under FEHB.
- Loss of coverage under spouse's non-Federal health plan if spouse **involuntarily** loses his or her coverage or coverage for his or her dependents.

If you are enrolled, you may change your enrollment only when an event permitting the change you want to make occurs (see table). However, you may change from self and family to self only at any time.

To enroll or change your enrollment, obtain an SF 2809 from your employing office, complete the form and return it to your employing office within the time limit specified in the table for the event permitting the enrollment or enrollment change.

IMPORTANT

You will not be eligible for health benefits coverage after retirement unless you are enrolled before you retire and meet all the requirements for continuation of enrollment after retirement (see page 8).

Temporary Employees Eligible for FEHB Under 5 U.S.C. 8906a.

If you are a temporary employee with an appointment for one year or less who has completed one year of current continuous employment, excluding any break in service of five days or less, you are eligible under section 8906a of the FEHB law to participate in the FEHB Program. All of the above enrollment and enrollment change information applies to you with one exception. A decision not to enroll will not affect your future eligibility to continue FEHB enrollment after retirement (see pge 8).

EFFECTIVE DATES

In general, enrollments and enrollment changes take effect on the first day of the pay period that begins after your employing office receives your completed SF 2809 and follows a pay period during any part of which you were in a pay status. (The pay status requirement doesn't apply to a change from self and family to self only.)

There are exceptions --

- **Open Season.** Your employing office can give you the specific day on which your enrollment or enrollment change will take effect.
- **Change from Self Only to Self and Family Due to the Birth or Addition of a Child as a New family Member.** This change takes effect on the first day of the pay period in which the child is born or becomes an eligible family member, regardless of your pay status.
- **Cancellation.** See page 9.

Additional information about effective dates appears in the table on page 13.

Note: If you change plans or change options in your current plan, and you or a family member covered by your prior plan or option are confined in a hospital on the date your enrollment change takes effect, benefits of the prior plan or option will continue temporarily for the confined person. Benefits will continue (unless they are exhausted) for each additional day of continuous confinement through the 91st day after the date your enrollment change takes effect. Benefits of the new plan or option will not begin for the confined person until the day after his or her confinement ends or the 92nd day after the date your enrollment change takes effect, whichever is earlier.

IDENTIFICATION CARDS

Once your enrollment or enrollment change is processed, your plan will send you an identification card. However, you should keep the copy of the SF 2809 your employing office gives you for your records. If you need to obtain benefits before you receive your identification card, contact your plan for assistance and use your copy of the SF 2809 as proof of your enrollment or enrollment change. Do not send bills or claims to your employing office or the Office of Personnel Management.

COORDINATION OF BENEFITS

Double Coverage

Because many people covered by FEHB plans also have other health care protection, all FEHB plans have a coordination of benefits (COB), or double coverage, provision. The provision applies when a person covered by an FEHB plan is also entitled to benefits under any other kind of group health insurance, Medicare or no-fault or other automobile insurance that pays benefits without regard to fault. The purpose of the provision is to enable enrollees and covered family members to recover as much of their health care expenses as their total coverage permits, but not more than the actual charges for the care. Under COB, or double coverage, one plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. The combined amount paid by both plans will usually equal 100% of covered, or allowable, expenses.

Say, for example, that a peson with double coverage is charged $100.00 for medical services received, that the actual charge is an allowable expense of both plans, and that the benefit of each plan is 80% of the allowable expense. Normally, the plan designated as the primary payer would pay $80.00, or its benefit in full, and the plan designated as the secondary payer would pay only the remaining $20.00.

Except for Medicare, primary and secondary payers are determined according to the guidelines of the National Association of Insurance Commissioners. Generally, the plan that covers you as an enrollee is the primary payer; the plan that covers you as a family member is the secondary payer.

The COB provision helps reduce the FEHB plan premium that you pay.

FEHB Plans and Medicare

Plans under the FEHB Program typically provide protection against the same kinds of expenses as Medicaare, which has two parts (Part A, hospital insurance, and Part B, medical insurance). Under the law, if you're an employee age 65 or over and have Part A, your FEHB plan is the primary payer and Medicare is the secondary payer of benefits provided under both your plan and Medicare Part A or Part B. Medicare is also the secondary payer of mutually provided benefits for your covered spouse, regardless of your age, if he or she is age 65 or over and has Part A.

> Note: After you retire, Medicare will become the primary payer and your FEHB plan will be the secondary payer for you (unless you are reemployed by the Government), and for your covered spouse (unless he or she is employed by the Government).

In addition, your FEHB plan is the primary payer and Medicare is the secondary payer of mutually provided benefits for an End Stage Renal Disease (ESRD) Medicare beneficiary under age 65 within the first 12 months of ESRD care. Also, your FEHB plan is the primary payer and Medicare is the secondary payer for a person under age 65 entitled to Medicare on the basis of disability.

FEHB Plans and Uniformed Services Health Benefits Program

If you are eligible for health care coverage under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), your FEHB plan is the primary payer of benefits, and CHAMPUS is the secondary payer.

CIRCUMSTANCES PERMITTING CONTINUATION OF ENROLLMENT

Transfer

Your enrollment will continue without change if --

- You transfer to (or are reemployed by) another Federal agency without a break in service of more than three calendar days, and
- You are eligible for FEHB Program coverage in your new position.

> Note: If you are not enrolled in an FEHB plan at the time you transfer, you will have an opportunity to enroll if you have a break in service of more than three days and you are eligible for FEHB coverage in the new position.

Leave Without Pay (LWOP)

If you go on LWOP (or your pay isn't enough to cover your share of the premium), your enrollment will continue for up to one year, unless you cancel it (see page 9). However, you are responsible for paying your share of the premium. Your employing office will tell you how to make the premium payments.

Military Service

Your enrollment will continue without change if you enter on active duty in the military service for 30 days or less.

If you enter on active duty for more than 30 days, your enrollment will continue for up to one year, unless you elect to have the enrollment terminated (see page 9). You are responsible, however, for paying your share of the premium (your employing office will explain how to make the premium payments). If you elect to have your enrollment terminated, it will be reinstated at the time you exercise your reemployment rights and return to civilian service. (You may also change your enrollment, or enroll if you were not enrolled when you entered on active duty, within 31 days after returning to civilian service.)

Your decision to have your enrollment terminated will not affect your future eligibility to continue FEHB enrollment after retirement (see below).

Retirement

Your enrollment will continue without change in benefits or affect your future eligibility to continue FEHB enrollment after retirement (see below).

- Under a retirement system for Federal civilian employees and
- On an immediate annuity.

In addition, you must be currently enrolled in a plan under the FEHB Program and must have been enrolled (or covered as a family member) in an FEHB plan for --

- The five years of service immediately before retirement, or
- If fewer than five years, all service since your first opportunity to enroll. (Generally, your first opportunity to enroll is within 31 days after your first appointment [in your Federal career] to a position under which you are eligible to enroll under conditions that permit a Government contribution toward the enrollment.)

Note 1: "Service" means service in which you were eligible to be enrolled in an FEHB plan under conditions that permitted a Government contribution toward the enrollment. Your enrollment (or coverage) need not have been in the same plan, but it must have been in one or more FEHB plans. Coverage under a non-FEHB plan is not creditable toward meeting the five-year or first-opportunity requirement. (In some circumstances, if you are enrolled in an FEHB plan at the time of retirement, your past coverage under CHAMPUS may be creditable toward meeting the five-year or first opportunity requirement. Contact your employing office for details.

Note 2: While the Office of Personnel Management has the authority to waive the five-year requirement for continuation of enrollment after retirement, **this authority is limited to extraordinary situations only and is rarely exercised.**

Workers' Compensation

Your enrollment continues while you are receiving compensation from the Office of Workers' Compensation Programs if the Secretary of Labor determines that you are unable to return to duty and if you were enrolled in the FEHB Program (or covered as a family member) for (1) the five years of service immediately before the compensation started, or (2) all service since your first opportunity to enroll. (Notes 1 and 2 above also apply to Workers' Compensation.)

Death

If you die while you are enrolled for self and family, the enrollment will continue for your eligible survivor annuitants and other eligible family members with no change in benefits or cost. (However, survivors of deceased Postal Service employees will pay the same share of the premium as other Federal survivor annuitants.) If there is only one survivor annuitant, and he or she is the sole eligible family member, the enrollment will be changed automatically to self only, with a corresponding reduction in cost.

CANCELLATION OF ENROLLMENT

You may voluntarily cancel your enrollment at any time by submitting a properly completed Standard Form (SF) 2809 to your employing office.

However, if you cancel your enrollment, neither you nor any family member covered by your enrollment will be entitled to a 31-day extension of coverage for conversion to nongroup coverage (see page 10). Moreover, family members who lose coverage because of your cancellation will not be eligible for temporary continuation of coverage (see page 10).

Effective Date of Cancellation

If you are on a biweekly pay period --

- The cancellation will take effect on the last day of the pay period in which your employing office receives your SF 2809.

If you are on a monthly or 4-week pay period, and your employing office receives your SF 2809 --

- More than 15 days before the end of the pay period, the cancellation will take effect on the last day of that pay period.
- Less than 15 days before the end of the pay period, the cancellation will take effect on the last day of the following pay period.

Note: If you intend to be covered by someone else's enrollment at the time you cancel and wish to avoid a gap in your coverage, you should coordinate the effective date of your cancellation with the effective date of your new coverage. (See page 7 for additional information on effective dates.)

Once your cancellation becomes effective, you may not enroll again until an event occurs that permits enrollment, such as marriage or Open Season (see the table on page 13).

In addition, you will not be eligible for health benefits coverage after retirement unless you reenroll before you retire and meet all the requirements for continuation of enrollment after retirement (see page 8).

Note: Some employees who cancel their enrollment may plan to reenroll in time to qualify for FEHB coverage as a retiree; however, there is always the risk that they will have to retire earlier than expected (*e.g.*, due to disability or involuntary separation) and not be able to meet the five-year requirement for continuing FEHB coverage into retirement. Please understand that when you cancel your enrollment you are voluntarily accepting this risk. An alternative would be to change to a lower cost plan so that you meet the requirements for continuation of your FEHB enrollment after retirement.

TERMINATION OF ENROLLMENT

Your enrollment will end on the last day of the pay period in which --

- You are separated from your job, unless you are separated under circumstances that allow you to continue your enrollment (see page 8).
- You become ineligible for coverage because of a change in your employment status.
- You die, and there is no eligible survivor annuitant to continue the enrollment.

Your enrollment also will end on --

- The last day of the pay period that includes your 365th day of continuous nonpay status.
- The day you are separated, furloughed or placed on leave of absence to enter military service for more than

30 days, if you elect to have your enrollment terminted (see page 8).

31-DAY EXTENSION OF COVERAGE

Your coverage will continue for 31 days after your enrollment ends for any reason except voluntary cancellation in order to give you the opportunity to convert to an individual (non-group) health benefits contract.

If you are confined in a hospital on the 31st day, the benefits under your FEHB plan will continue for up to 60 more days of continuous confinement.

These extensions of coverage are without cost to you and also apply to your family members who lose coverage for any reason except your voluntary cancellation.

CONVERSION RIGHTS

- If your enrollment ends for any reason except voluntary cancellation, you may convert to nongroup coverage without giving evidence of good health.
- Any member of your family who loses coverage for any reason except your voluntary cancellation may also convert to nongroup coverage.
- Nongroup coverage under a conversion contract is available only from the carrier of the FEHB plan you are enrolled in when your enrollment ends.

Applying for a Conversion Contract

Within 60 days after your enrollment ends, your employing office must give you a notice of termination of your enrollment and the right to convert to an individual conract with the carrier of your plan.

If you want to convert to nongroup coverage, write for information to the nearest office of your plan within:

- 91 days after your enrollment ends, or
- 31 days after the date the notice was signed by an authorized official, whichever is earlier.

> Note: If you don't receive the notice within 60 days after your enrollment ends, or you can show that you did not apply for a conversion contract in a timely manner for reasons beyond your conrol, you may request conversion to nongroup coverage by writing to your plan within six months from the day on which your enrollment ends. Your request must be accompanied by verification of your loss of FEHB coverage, e.g., a Standard Form 50 showing your separation from the service.

If a member of your family wants to convert to nongroup coverage, you or the family member should write to the nearest office of your plan within 31 days after the family member's FEHB coverage ends. (Although you will be notified when your enrollment ends, no one will notify you or the family member when he or she loses coverage.)

The carrier will then send you or the family member an application form as well as benefit and cost information about the nongroup coverage.

Effective Date of a Conversion Contract

Nongroup coverage takes effect at the end of the 31-day extension of coverage described above. This is true even if you or a family member are confined in a hospital on the 31st day and continue to receive benefits for that confinement under your FEHB plan for up to 60 more days.

Some Basic Differences Between a Conversion Contract and an FEHB Plan

- Nongroup benefits and premiums are not subject to Government review and approval.
- The benefits available under a conversion contract may not be the same as those under your FEHB plan. In fact, many carriers provide fewer benefits under their nongroup contracts.
- Nongroup coverage is likely to cost you more because the Government doesn't pay part of the premium, and you will not have the advantage of a "group rate."

TEMPORARY CONTINUATION OF COVERAGE

If your enrollment is terminated because you separate from service on or after January 1, 1990, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program after separation. Temporary continuation of coverage is available to you if your separation is voluntary or involuntary (unless it is for gross misconduct), and you would not otherwise be eligible for continued coverage under the Program. An example is separation for retirement when you are unable to meet the requirements for continuation of enrollment after retirement (see page 8).

Your temporary coverage continues for up to 18 months after your separation from service, and you must pay the total premium (both the Government and employee shares), plus a charge for administrative expenses of 2% fo the total premium. When your temporary continuation of coverage ends (except by cancellation or nonpayment of premiums), you will be entitled to a 31-day extension of coverage for conversion to nongroup coverage (see above).

Electing Temporary Continuation of Coverage

Your employing office will notify you of your opportunity to elect temporary continuation of coverage within 61 days after your enrollment terminates because of separatin from service. You have 60 days after separation (or after receiving the notice, if later) to elect continued coverage. Complete a Standard Form (SF) 2809 obtained from your employing office. You may choose --

- The same plan, option and type of enrollment that covered you at the time of separation; or

- Any other plan (for which you are eligible), option or type of enrollment.

Return the properly completed form to the employing office within the 60-day time limit.

Effective Date of Coverage

Your temporary continuation of coverage takes effect on the day after the 31-day extension of coverage described on page 10. Coverage is retroactive if you return the SF 2809 to the employing office after the 31-day extension period ends.

Other Individuals Eligible for Temporary Continuation or Coverage

On and after January 1, 1990, children who lose FEHB coverage and former spouses who are not eligible to enroll in the FEHB Program under the Spouse Equity law or similar statutes (see page 6) may also be eligible for temporary continuation of coverage. Their temporary coverage continues for up to 36 months after the qualifying event occurs, *e.g.*, child reaches age 22 or divorce.

Child and former spouse enrollees also must pay the total premium plus the 2% administrative charge and are entitled to a 31-day extension of coverage for conversion to non-group coverage when their temporary continuation of coverage ends (except by cancellation or nonpayment of premiums).

If temporary continuation of coverage is desired for your child or former spouse, your employing office must be notified when the child or former spouse becomes eligible. For a child, you must notify the employing office within 60 days after the qualifying event occurs. For a former spouse, you or the former spouse must notify the employing office within 60 days after the former spouse's change in status. The employing office then notifies the child or the former spouse of his or her temporary continuation of coverage rights. If a child wants continued coverage, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants continued coverage, he or she must make the election within 60 days after the later of:

- The date of the qualifying event:
- The date he or she loses coverage as an enrolled former spouse because of remarriage or loss of qualifying court order; or
- The date he or she receives the notice.

> Note: In the case of a child who becomes eligible for temporary continuation of coverage. If the employing office is not notified by the enrolee within the 60-day time limit, the opportunity to elect continued coverage ends 60 days after the qualifying event; in the case of a former spouse, if the employing office is not notified by the enrollee or the former spouse within the 60-day time limit, the opportunity to elect continued coverage ends 60 days after the change in status. If someone other than the enrollee notified the employing office about a child's eligibility (or someone other than the enrollee or former spouse, in the case of a former spouse's eligibility), the employing office notifies the child (or former spouse) of his or her temporary continuation of coverage rights, but no additional time is given.

For a child who elects temporary continuation of coverage, the effective date of coverage is the same as described above. For a former spouse who elects temporary continuation of coverage, the effective date of coverage is the same as described above or the date of the qualifying event, if later.

COST CONTAINMENT

To ensure that enrollees and covered family members receive the best qualify of care in an environment of constantly rising health care costs, all FEHB plans have instituted cost containment programs. These programs, which include, for example, precertification of hospital admissions and case management, are designed to help make sure that services are performed at the right time, in the right place and at the right price. It is important that you and your covered family members be sound consumers of health care services and adhere to the cost containment programs your plan has established.

REVIEW OF CLAIMS

Read the plan brochure to become familiar with your plan's benefits and claims procedures. Questions concerning benefits, claim payments and claim processing **must** be address to your plan. The Office of Personnel Management (OPM) does not pay or process claims.

If your plan denies your claim for payment or for service, it will reconsider the denial upon receipt of a written request within one year of the denial. The written request should state, in terms of applicable brochure provisions, the reasons you believe the denied claim for payment or service should have been paid or provided. Within 30 days after receipt of your request for reconsideration, the plan must affirm the denial in writing to you, pay the claim, provide the service, or request additional information from you or your health care provider reasonably necessary for making a determiantion. (Your plan must notify you if it has requested additional information from your provider.) If this information is not supplied within 60 days, the plan will be its decision on the information it has on hand. If the plan affirms its denial, you have a right to a review by OPM to determine whether the plan has acted in accordance with its contract. Before seeking OPM review of a claim, these are some of the things you should keep in mind:

- Do not submit initial bills from providers for payment to the below address or any other office within OPM; send them to the plan along with the appropriate claim form.
- Providers may use this procedure only on behalf of and with the specific written consent of the member, and are required to demonstrate that the member has assigned all of his or her rights to the provider with regard to that particular claim.
- You should first check with your provider or facility to be sure the plan was billed correctly; for instance, was the correct procedure code(s) used, were complications correctly indicated on the billing or operative report, etc. Reasonable and customary (R&C) allowances are determined and controlled solely by the plan based upon information available to it.
- Along with your request for review, you must send a copy of the plan's reconsideration decision.

OPM review may be obtained by writing to:

U.S. Office of Personnel Management
Insurance Review Division
Retirement and Insurance Group
P.O. Box 436
Washington, D.C. 20044

OPM must receive your request for review, along with a copy of your letter to the plan and its reply, within 90 days of the plan's affirmation of the denial. You may also ask OPM for a review if the plan fails to respond within 30 days to your written request for reconsideration or within 30 days after you have supplied additional information. In this case, OPM must receive a request for review within 120 days of your request to the plan for reconsideration or the date you were notified that the plan needed additional information. In your request for review, show (1) the date of your request to the plan or (2) the dates the plan requested and you provided additional information to the plan. OPM will notify you and the plan of its decision.

If you decide to seek judicial review of the denial of a claim, you must file suit no later than December 31 of the third year after the year in which the care or service was provided, or two years after a final determination has been made on the claim by OPM through the disputed claims process, whichever is later. Federal law governs claims for relief that relate to benefits under an FEHB plan. Damages recoverable under Federal law are limited to me amount of benefits in dispute, plus simple interest and court costs. Under Federal regulations (5 CFR 890.107), such legal actions should be brought against the carrier of your plan.

Privacy Act Statement -- If you request OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S. Code, to use the information collected from you and the plan to determine if the plan has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the plan in support of OPM's decision on the disputed claim.

TABLE OF PERMISSIBLE CHANGES IN ENROLLMENT

Enrollment May Be Cancelled or Changed From Family to Self Only at Any Time

No.	Events That Permit Enrollment Change Event	Change Permitted From Not Enrolled to Enrolled	From Self Only to Family	From One Plan or Option to Another	Time Limit in Which Registration Form Electing Change Must Be Filed With Employing Office**
1	**Open Season.**	Yes*+	Yes	Yes	**As announced by the Office of Personnel Management.**
2	**Change in marital status. (Marriage, divorce, annulment, death of spouse.)**	Yes*+	Yes (Except former spouses)	Yes (Except former spouses)	**From 31 days before to 60 days after change in martial status.**
3	**Other change in family status. (For example, birth of a child, legal separation, discharge from military service of a spouse or of a child under age 22).**	No	Yes	No	**Within 60 days after change in family status.**
4	**Enrollee or family member moves from an area served by a prepaid plan (CMP/HMO) in which enrolled at time of move.**	Does not apply	Yes	Yes	**At any time after presenting written notice to the employing office of the move.**
5	**Termination of enrollment by employee organization plan because of termination of membership in organization.**	Does not apply	No	Yes	**Within 31 days after termination of enrollment in plan.**
6	**Employee, annuitant or former spouse (spouse equity), covered as a family member under another's FEHB enrollment, loses coverage other than by cancellation or change to Self Only of the covering enrollment; or employee, covered under another federally sponsored health benefits program, loses such coverage for any reason.**	Yes*	Does not apply	Does not apply	**Within 31 days after termination (except, for employees, withihn 60 days after the death of the enrollee). Coverage is effective the first day of the pay period that begins after the employing office receives the SF 2809. If election is made within the time limit, but after expiration of the 31-day extension of coverage (or too close to the expiration of the 31-day extension of coverage), there will be a break in coverage.**
7	**Employee, annuitant or former spouse (spouse equity), covered as a family member under another's FEHB enrollment, loses coverage because of change of the covering enrollment from Family to Self Only.**	Yes, for Self Only*	Does not apply	Does not apply	**Within 31 days after change of covering enrollment has been filed. Coverage is effective the first day of the pay period that begins after the employing office receives the SF 2809. If election is made within the time limit, but during a pay period following the one in which the change to Self Only was filed, there will be a break in coverage.**
8	**Employee transfers to overseas post of duty from the United States, or reverse.**	Yes*	Yes	Yes	**Within 31 days before or after move.**
9	**Employee returns to active civilian duty or annuitant separates from military service which was not limited to 30 days or less.**	Yes*+	Yes	Yes	**Within 31 days after return to active civilian duty or separation from military service.**
10	**Your plan stops participating in the FEHB Program.**	Does not apply	Yes	Yes	**As set by the Office of Personnel Management.**
11	**Self Only enrollment under this Program of employee's or annuitant's spouse terminates as a result of change in spouse's Federal employment status of 365 days' nonpay status.**	No	Yes	No	**Within 31 days after termination of spouse's enrollment. Coverage is effective the first day of the pay period that begins after the employing office receives the SF 2809. If election is made within the time limit, but after expiration of the 31-day extension of coverage (or too close to the expiration of the 31-day extension of coverage), there will be a break in coverage.**
12	**Employee who is not enrolled loses coverage under parent's non-Federal health plan.**	Yes*	Does not apply	Does not apply	**Within 31 days after loss of coverage, except within 60 days after the death of the parent.**
13	**Enrolled employee retires from overseas post of duty and is eligible to continue enrollment as annuitant.**	Does not apply	Yes	Yes	**Within 60 days after retirement.**
14	**Enrollee becomes eligible for Medicare.**	Does not apply	No	Yes	**At any time beginning 30 days before becoming eligible for Medicare.**
15	**Enrollee's eligible child (or children) loses coverage under another's FEHB enrollment.**	No	Yes	No	**Within 31 days after child's (children's) loss of coverage. Coverage is effective the first day of the pay period that begins after the employing office receives the SF 2809. If election is made within the time limit, but after expiration of the 31-day extension of coverage (or too close to the expiration of the 31-day extension of coverage), there will be a break in coverage.**

*** Individuals must be otherwise eligible to enroll.**
+ Employees only.

**** Also selected effective date information.**

No.	Events That Permit Enrollment Change Event	Change Permitted From Not Enrolled to Enrolled	From Self Only to Family	From One Plan or Option to Another	Time Limit in Which Registration Form Electing Change Must Be Filed With Employing Office**
16	**Employee or an eligible family member loses coverage under Medicaid (State program of medical assistance for the needy).**	Yes* *employee loss*	Yes *family member loss*	Does not apply	**Within 31 days after termination of Medicaid or loss of Medicaid coverage by family member.**
17	**Employee, annuitant or former spouse (spouse equity), covered as a family member under another's FEHB enrollment, loses coverage due to cancellation of the covering enrollment.**	Yes*	Does not apply	**You must enroll in the same plan and option as that from which coverage is lost, if eligible to enroll in that plan, within 31 days after cancellation of the covering enrollment. If not eligible to enroll in that plan, you may enroll in the same option of any available plan within the 31-day period. Coverage is effective the first day of the pay period that begins after the employing office receives the SF 2809. If election is made within the time limit, but during a pay period following the one in which the cancellation was filed, there will be a break in coverage.**	
18	**Enrolled employee's employment status changes from full-time to part -time career employmetn as defined in the Federal Employees Part-Time Career Employment Act of 1978.**	No	No	Yes	**Within 31 days after the change in employment status.**
19	**Employee or employee's spouse loses coverage under spouse's non-Federal health plan when spouse terminates employment to accompany employee who accepts a position is directed out of commuting area.**	Yes*	Yes	No	**Within 31 days before or 180 days after move.**
20	**Employee's or annuitant's spouse involuntarily loses his or her non-Federal health insurance coverage, or coverage for his or her dependents; or employee's or annuitant's eligible child (or children) loses non-Federal coverage under the other parent's health plan because the other parent involuntarily loses coverage for his or her dependents.**	Yes*+	Yes	No	**Within 31 days before or after spouse's or dependent's loss of coverage; or within 31 days before or after child's (or children's) loss ov coverage.**
21	**Former spouse who is eligible to enroll under the authority of the Civil Service Retirement Spouse Equity Act of 1984 (P.L. 948-615), as amended, the intelligence Authorization Act of 1986 (P.L. 99-569), or the Foreign Relations Authorization Act, Fiscal Years 1988 and 1989 (P.L. 100-204).**	Yes*	Does not apply	Does not apply	**Generally, within 60 days after divorce or within 60 days after the date of OPM's notice of eligibility to enroll.**
22	**Temporary employee completes one year of service in accordance with 5 U.S.C. 8906a.**	Yes*	Does not apply	Does not apply	**Within 31 days after becoming eligible.**
23	**Temporary employee, eligible under 5 U.S.C. 8906a, changes to a nontemporary appointment.**	Yes*	Yes	Yes	**Within 31 days after changing to non-temporary appointment.**
24	**Employee separated from service and eligible for temporary continuation of coverage.**	Does not apply	Yes	Yes	**Within 60 days after the later of: separation; or receiving notice of the opportunity to elect temporary continuation of coverage. Coverage is effective the day after other FEHB coverage ends, including the 31-day extension of coverage. If election is made after the end of the 31-day extension of coverage, the effective date will be retroactive.**
25	**Child of employee, former employee or annuitant stops meeting the requirements for unmarried dependent children.**	Yes*	Does not apply	Does not apply	**Within 60 days after the later of: the qualifying event; of the child's receiving notice of the opportunity to elect temporary continuation of coverage (based on the enrollee's notification to the employing office of the child's eligibility). Coverage is effective the day after other FEHB coverage ends, including the 31-day extension of coverage. If election is made after the end of the 31-day extension of coverage, the effective date will be retroactive.**

*** Individuals must be otherwise eligible to enroll.**
+ Employees only.

**** Also selected effective date information.**

No.	Events That Permit Enrollment Change Event	Change Permitted From Not Enrolled to Enrolled	From Self Only to Family	From One Plan or Option to Another	Time Limit in Which Registration Form Electing Change Must Be Filed With Employing Office**
26	Former spouse meets the requirement in 5 U.S.C. 8901(10) of having been enrolled in an FEHB plan as a covered family member at some time during the 18 months before the marriage ended, but does not meet one or both of the other two requirements of 5 U.S.C. 8901(10).	Yes*	Does not apply	Does not apply	Within 60 days after the later of: the qualifying event; the date coverage under Subpart H of 5 CFR Part 890 was lost, if the loss occurred within 36 months of the qualifying event; or the former spouse's receiving notice of the opportunity to elect temporary continuation of coverage (based on the enrollee's or former spouse's notification to the employing office of the former spouse's eligibility). Coverage is effective the day after other FEHB coverage ends, including the 31-day extension of coverage; or the date of the qualifying event, if later. If election is made after the end of the 31-day extension of coverage or the date of the qualifying event, the effective date will be retroactive.
27	Former employee, former spouse or child whose temporary continuation of coverage under 5 CFR Part 890 Subpart K terminates due to other FEHB coverage, loses the other FEHB coverage.	Yes*	Does not apply	You must reenroll in the same plan and option as that in which you were enrolled prior to obtaining the other FEHB coverage, if eligible to enroll in that plan, within 31 days after the other coverage ends, but not later than the expiration of the period of eligibility for the temporary continuation of coverage. If not eligible to enroll in that plan, you may enroll in the same option of any available plan within the 31-day time limit.	

*** Individuals must be otherwise eligible to enroll.**
+ Employees only.

**** Also selected effective date information.**